

APPENDIX B
AMSEL-TY Form 175-R-E

| PERSONNEL INJURY/PROPERTY DAMAGE ACCIDENT/INCIDENT INVESTIGATION REPORT <small>Use in Accordance with TYAD Regulation 385-1; Proponent Office is AMSEL-TY-RK-S</small> | | | | | | |
|--|--|--|--------------------------------------|---|--|--|
| Name: George Smith | | Age: 43 | SSN: 678-90-1234 | | | |
| Sex: <input checked="" type="checkbox"/> Male <input type="checkbox"/> Female | Mishap Date: 22 Jul 99 | | Mishap Time: 0930 AM PM | | | |
| Employee Grade: WG-07 | Employee Job Title: Automobile Mechanic | | | | | |
| Supervisor: Fredrick Hill | | Supervisor's Phone Number: 56113 | | | | |
| Directorate: Community Services | Division: Recreation | Cost Center: Q1817 | | | | |
| Mishap Location: Storage Facility | | | | | | |
| Describe activity/task performed at time of mishap: Employee was moving supplies and scraped his fingers on a steel shelving unit. | | | | | | |
| Was activity/task employee's normal work activity? Yes No <input checked="" type="checkbox"/> <input type="checkbox"/> | | | | | | |
| Are there any witnesses? If yes, please list name and phone number: No | | | | | | |
| Property Damage: Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> If Yes, Estimated Amount: Describe: | | | | | | |
| SAMPLE | | | | | | |
| SEVERITY OF INJURY: <input type="checkbox"/> Death <input type="checkbox"/> First Aid <input type="checkbox"/> Hospitalization <input checked="" type="checkbox"/> No Lost Time <input type="checkbox"/> Lost Time <input type="checkbox"/> Light Duty | | | | | | |
| Mishap Description: While moving supplies, employee scraped his fingers. | | | | | | |
| MISHAP BODY PART INJURY: (Mark all that apply) <table style="width:100%; border: none;"> <tr> <td style="vertical-align: top;"> <input type="checkbox"/> ABDOMEN <input type="checkbox"/> ARM/UPPER <input type="checkbox"/> ARM/LOWER <input type="checkbox"/> BACK <input type="checkbox"/> CHEST <input type="checkbox"/> EAR <input type="checkbox"/> ELBOW </td> <td style="vertical-align: top;"> <input type="checkbox"/> EYE <input checked="" type="checkbox"/> FINGER <input type="checkbox"/> FOOT <input type="checkbox"/> FOOT/ANKLE <input type="checkbox"/> GROIN <input type="checkbox"/> HAND/WRIST <input type="checkbox"/> HEAD </td> <td style="vertical-align: top;"> <input type="checkbox"/> HIP <input type="checkbox"/> KNEE <input type="checkbox"/> LEG <input type="checkbox"/> MOUTH <input type="checkbox"/> NECK <input type="checkbox"/> TOE <input type="checkbox"/> OTHER _____ </td> </tr> </table> | | | | <input type="checkbox"/> ABDOMEN <input type="checkbox"/> ARM/UPPER <input type="checkbox"/> ARM/LOWER <input type="checkbox"/> BACK <input type="checkbox"/> CHEST <input type="checkbox"/> EAR <input type="checkbox"/> ELBOW | <input type="checkbox"/> EYE <input checked="" type="checkbox"/> FINGER <input type="checkbox"/> FOOT <input type="checkbox"/> FOOT/ANKLE <input type="checkbox"/> GROIN <input type="checkbox"/> HAND/WRIST <input type="checkbox"/> HEAD | <input type="checkbox"/> HIP <input type="checkbox"/> KNEE <input type="checkbox"/> LEG <input type="checkbox"/> MOUTH <input type="checkbox"/> NECK <input type="checkbox"/> TOE <input type="checkbox"/> OTHER _____ |
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| TYPE OF INJURY: <table style="width:100%; border: none;"> <tr> <td style="vertical-align: top;"> <input checked="" type="checkbox"/> ABRASION <input type="checkbox"/> AMPUTATION <input type="checkbox"/> BRUISE <input type="checkbox"/> BURN <input type="checkbox"/> ELECTRICAL SHOCK </td> <td style="vertical-align: top;"> <input type="checkbox"/> OBJECT IN EYE <input type="checkbox"/> FRACTURE <input type="checkbox"/> HERNIA <input type="checkbox"/> LACERATION <input type="checkbox"/> PUNCTURE WOUND </td> <td style="vertical-align: top;"> <input type="checkbox"/> RASH <input type="checkbox"/> SPRAIN/STRAIN <input type="checkbox"/> OTHER _____ <input type="checkbox"/> NONE </td> </tr> </table> | | | | <input checked="" type="checkbox"/> ABRASION <input type="checkbox"/> AMPUTATION <input type="checkbox"/> BRUISE <input type="checkbox"/> BURN <input type="checkbox"/> ELECTRICAL SHOCK | <input type="checkbox"/> OBJECT IN EYE <input type="checkbox"/> FRACTURE <input type="checkbox"/> HERNIA <input type="checkbox"/> LACERATION <input type="checkbox"/> PUNCTURE WOUND | <input type="checkbox"/> RASH <input type="checkbox"/> SPRAIN/STRAIN <input type="checkbox"/> OTHER _____ <input type="checkbox"/> NONE |
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|---|--|--|---|--|--|
| UNSAFE ACT/CONDITION: <div style="display: flex; justify-content: space-between;"> <div style="width: 48%;"> <input type="checkbox"/> ADJUST MACHINERY WHILE RUNNING <input checked="" type="checkbox"/> DID NOT RECOGNIZE HAZARD <input type="checkbox"/> DISREGARDED INSTRUCTIONS <input type="checkbox"/> FAILURE TO SECURE <input type="checkbox"/> IMPROPER PROCEDURE <input type="checkbox"/> IMPROPER SUPERVISION <input type="checkbox"/> IMPROPER VEHICLE OPERATION <input type="checkbox"/> PROTECTIVE EQUIPMENT (improper selection, usage/ maintenance) </div> <div style="width: 48%;"> <input type="checkbox"/> OPERATING AT UNSAFE SPEED <input type="checkbox"/> OPERATING WITHOUT AUTHORIZATION <input type="checkbox"/> UNSAFE LIFTING <input type="checkbox"/> UNSAFE LOADING <input type="checkbox"/> UNSAFE POSITION <input type="checkbox"/> USING DEFECTIVE EQUIPMENT <input type="checkbox"/> USING UNSAFE EQUIPMENT <input type="checkbox"/> OTHER: _____ environmental factors, human factors, inappropriate tools, resources, etc.] </div> </div> | | | | | |
| Why Was Unsafe Act Performed? Employee did not anticipate the possibility of injury. | | | | | |
| EMPLOYEE'S TRADE: <table style="width: 100%; border: none;"> <tr> <td style="width: 33%; vertical-align: top;"> <input type="checkbox"/> AIR COND. MECHANIC <input checked="" type="checkbox"/> AUTOMOTIVE MECHANIC <input type="checkbox"/> BOILER PLANT OPERATOR <input type="checkbox"/> CARPENTER <input type="checkbox"/> ELECTRICIAN <input type="checkbox"/> FIREFIGHTER <input type="checkbox"/> HEAVY EQ. OPERATOR </td> <td style="width: 33%; vertical-align: top;"> <input type="checkbox"/> LABORER <input type="checkbox"/> MACHINIST <input type="checkbox"/> OFFICE WORKER <input type="checkbox"/> PIPEFITTER <input type="checkbox"/> ROOFER <input type="checkbox"/> SECURITYS </td> <td style="width: 33%; vertical-align: top;"> <input type="checkbox"/> SEWAGE PLANT <input type="checkbox"/> SHEET METAL <input type="checkbox"/> WAREHOUSE <input type="checkbox"/> WELDER <input type="checkbox"/> MILITARY <input type="checkbox"/> OTHER: _____ </td> </tr> </table> | | | <input type="checkbox"/> AIR COND. MECHANIC <input checked="" type="checkbox"/> AUTOMOTIVE MECHANIC <input type="checkbox"/> BOILER PLANT OPERATOR <input type="checkbox"/> CARPENTER <input type="checkbox"/> ELECTRICIAN <input type="checkbox"/> FIREFIGHTER <input type="checkbox"/> HEAVY EQ. OPERATOR | <input type="checkbox"/> LABORER <input type="checkbox"/> MACHINIST <input type="checkbox"/> OFFICE WORKER <input type="checkbox"/> PIPEFITTER <input type="checkbox"/> ROOFER <input type="checkbox"/> SECURITYS | <input type="checkbox"/> SEWAGE PLANT <input type="checkbox"/> SHEET METAL <input type="checkbox"/> WAREHOUSE <input type="checkbox"/> WELDER <input type="checkbox"/> MILITARY <input type="checkbox"/> OTHER: _____ |
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| AGENCY OF MISHAP: <table style="width: 100%; border: none;"> <tr> <td style="width: 33%; vertical-align: top;"> <input type="checkbox"/> CHEMICAL <input type="checkbox"/> DEBRIS <input type="checkbox"/> ELECTRICAL <input type="checkbox"/> HAND TOOLS </td> <td style="width: 33%; vertical-align: top;"> <input type="checkbox"/> MACHINERY <input checked="" type="checkbox"/> MATERIAL HANDLING <input type="checkbox"/> RADIATION <input type="checkbox"/> RECREATIONAL </td> <td style="width: 33%; vertical-align: top;"> <input type="checkbox"/> STAIRS/LADDER <input type="checkbox"/> SURFACE <input type="checkbox"/> VEHICLE <input type="checkbox"/> OTHER: _____ </td> </tr> </table> | | | <input type="checkbox"/> CHEMICAL <input type="checkbox"/> DEBRIS <input type="checkbox"/> ELECTRICAL <input type="checkbox"/> HAND TOOLS | <input type="checkbox"/> MACHINERY <input checked="" type="checkbox"/> MATERIAL HANDLING <input type="checkbox"/> RADIATION <input type="checkbox"/> RECREATIONAL | <input type="checkbox"/> STAIRS/LADDER <input type="checkbox"/> SURFACE <input type="checkbox"/> VEHICLE <input type="checkbox"/> OTHER: _____ |
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| Employee's Suggestion to Prevent Recurrence: Wear gloves when moving materials onto shelving units. | | | | | |
| Supervisor's Recommendations to Prevent Recurrence: Concur with above. | | | | | |
| Safety Specialist's Recommendations to Prevent Recurrence: Concur with above, but ensure gloves are proper fitting and appropriate for the job. | | | | | |
| Supervisor's Signature/Date: | Safety Office Representative Signature/Date: | | | | |